Medically Fragile Foster Care Program Evaluation &
Medically Fragile Foster Parent & Social Worker Satisfaction Study

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The Jefferson/KIPDA Region's Medically Fragile Foster Care Program consists of 17 DCBS foster homes and a team of seven social workers. Medically fragile children have documented medical conditions that can abruptly change and become life threatening. This is the most vulnerable population served by DCBS and this program helps to keep these kids out of institutions. A nonexperimental design was used to determine the effectiveness of the Jefferson/KIPDA Region's DCBS Medically Fragile Foster Care Program. This evaluation focused on program processes. A purposive sample of 20 medically fragile children in the Jefferson/KIPDA Region was used. A chart file review was employed to collect data. Data collected was compared to ASFA, DCBS, and COA standards. Research questions are as follows: Is the Jefferson/KIPDA Region's DCBS Medically Fragile Foster Care Program effective? Does race have an effect on the length of stay or number of placement moves?

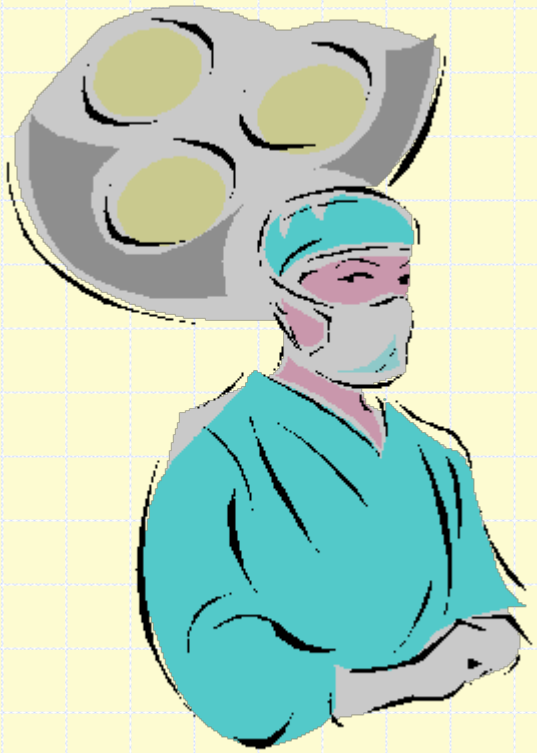
Results regarding effectiveness are as follows: 100% of the cases were in compliance with ASFA standards regarding length of stay, placement moves, and placement type relating to permanency goal. 100% of the case had current case plans and Continuous Quality Assessments (CQA). 100% of the case plans were related to case activities. 90% of the cases had no subsequent reports of abuse and/or neglect. 65% of the cases were in compliance regarding visitation (twice monthly). All children were visited at least once a month. A Mann Whitney U test was used to examine the effect of race on length of stay. A nonsignificant result (U= 39,ns) was found. A Mann Whitney U test was also used to examine the effect of race on number of placement moves. A nonsignificant result (U= 33, ns) was found. Race appears to have no bearing on a medically fragile child's length of stay in state's care or the number of placement moves they experience.

Six medically fragile foster parents and four DCBS social workers were interviewed using a semi-structured format. Interviews were tape recorded, transcribed, and then coded according to themes. Themes were placed in three columns and then lines were drawn connecting and collapsing similar themes. These themes were used to code the remaining data documents. Research questions are as follows: What could be done to improve training? What isn't working (in the program)? What is the most stressful aspect of your role?

Many suggestions were given regarding the improvement of training. They are as follows: Medically fragile social workers should attend trainings with foster parents. Foster parents and workers should get specific training from the child's care provider(s) (professionals). Training should explain how to get around some of the bureaucracy…how to get from point A to point B. Several areas of concern were expressed. There is a high rate of worker turnover. Workers get cases back when a child has died or has improved and is no longer medically fragile. Foster parents have a difficult time securing respite and do not like small segments of training (1-2 hrs.). Stressful aspects of the program are as follows: Foster parents have numerous appointments. They are afraid of what might happen to the child (i.e. the potential for death). Some foster parents find it stressful when a child has to leave their home. Workers are overwhelmed with paperwork and feel like there is too much micromanagement.

The program is meeting the needs of the medically fragile children and 90% of them are in the least restrictive setting. Needed services are acquired more quickly and cases are followed more closely than those of non-medically fragile children. There is a lot of support. Both foster parents and workers support and train one another. The most useful knowledge appears to be gained through experience. Coordination between agencies is working but could be improved by explaining everyone's role and expectations. Several medically fragile children get kicked out of the Medicaid system at the end of every month. It is unclear why this is happening. Other regions failed COA in this area because they did not have a specific team or worker assigned to cover medically fragile cases. This idea should be duplicated statewide. Workers should have some experience (1 year was suggested) and be trained before joining the team. Respite should be more accessible and is a source of stress for foster parents. It is extremely difficult to find a qualified respite provider for medically fragile children because they have so many physical problems and are at risk of death. Foster parents liked the recent changes in training where they are able to obtain all of their training hours (24 –annually) in one weekend session. However, they expressed the desire for this training to be held locally. Both foster parents and workers would like to be more involved in future policy & procedure changes.

DCBS MEDICALLY FRAGILE FOSTER CARE PROGRAM EVALUATION



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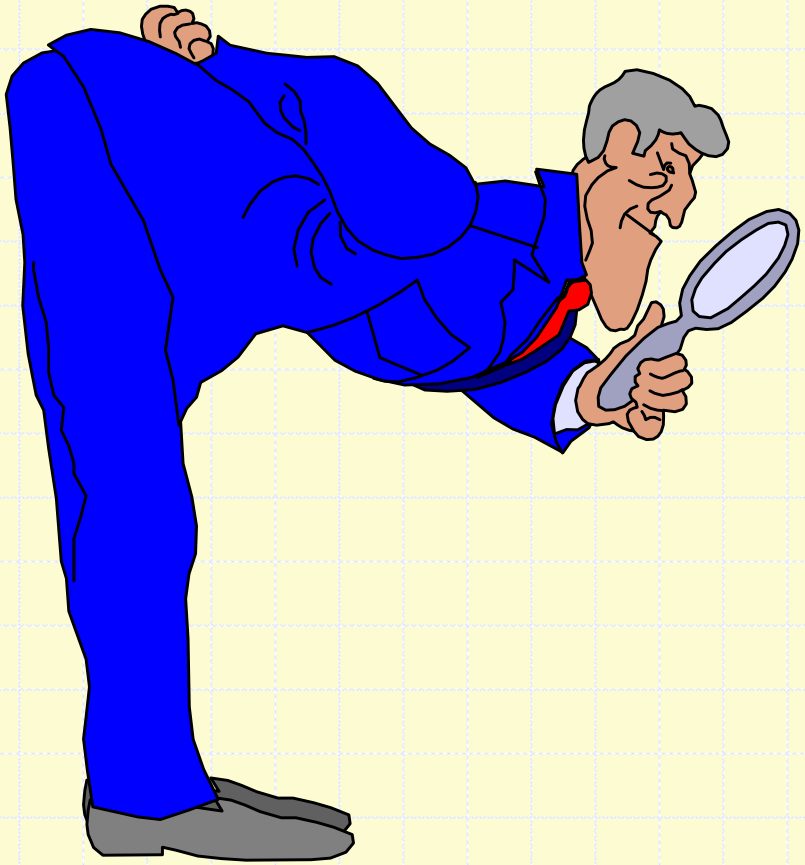
Introduction and Background

- Children have documented medical conditions that can abruptly change and become life threatening.
- Most vulnerable population served by DCBS.
- 17 DCBS medically fragile foster homes in this region
- Medically Fragile Team – 7 DCBS social workers
- Keeps kids out of institutions.
- “Children get the special care their natural families are unable to provide and through the support of foster families they receive the love and quality of life they could never receive in an institution”(Cabinet for Human Resources, 1992).

Quantitative Research Questions



- Is the program effective?
- Does race affect length of stay?
- Does race affect number of placement moves?

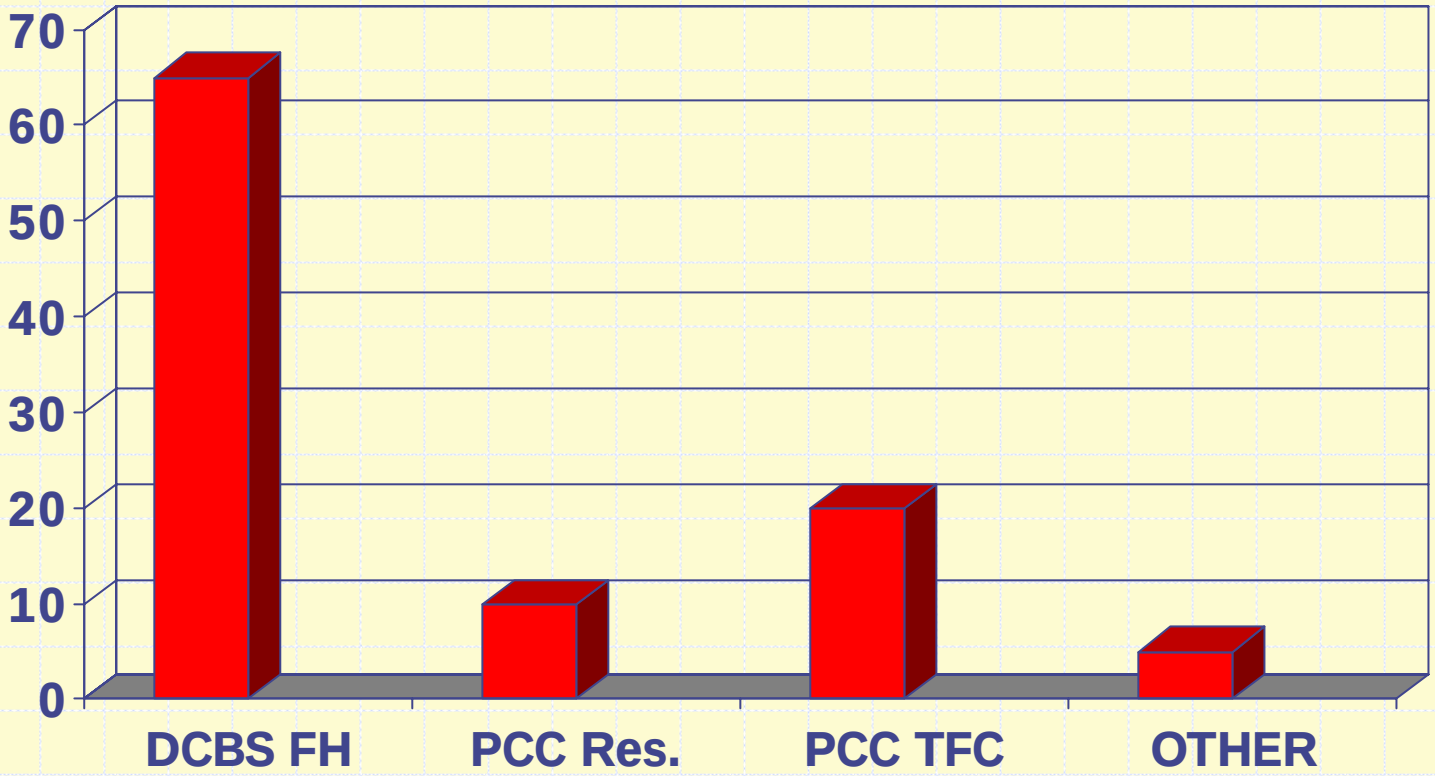
Research Design and Sample

- Nonexperimental.
- Purposive sampling of 20 medically fragile foster children in the Jefferson/KIPDA Region
- Chart file review
- Effectiveness was determined by comparing case files to DCBS and COA standards.
- Placement Type - Least restrictive environment
- Number of moves
- Are the case plans and CQAs current?
- Case plans related to case activities
- ASFA
- Subsequent reports of abuse and/or neglect
- SW visits

Is the program effective?

- Avg. # of placement moves – 1
- Current CQAs and case plans – 100%
- Case activities related to case plan – 100%
- ASFA timelines – 100%
- Subsequent abuse/neglect reports – 10%
- Avg. # of monthly SW visits – 1.65

Is the program effective? Are children placed in the least restrictive setting?

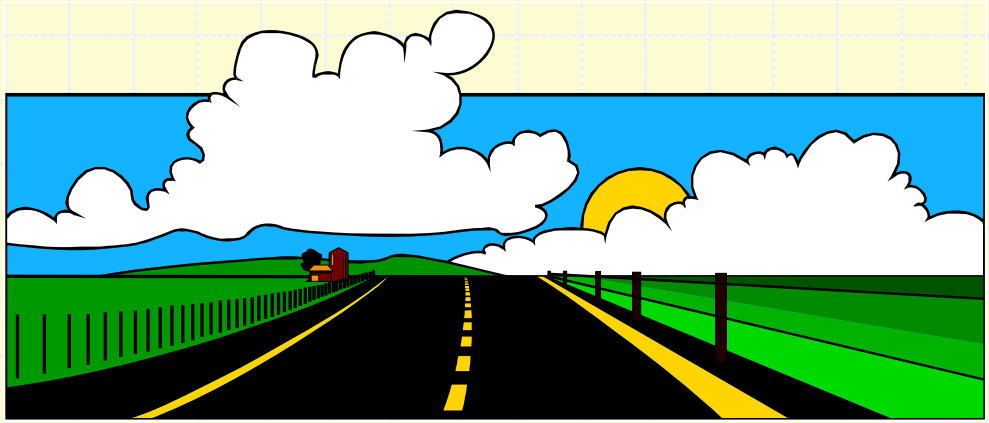


Does race affect length of stay?

- **A nonsignificant Mann Whitney U test result (U= 39,ns) was found. Race appears to have no bearing on length of stay.**

Does race affect on the # placement moves?

- **A nonsignificant Mann Whitney U test result (U= 33, ns) was found. Race appears to have no bearing on the number of placement moves.**

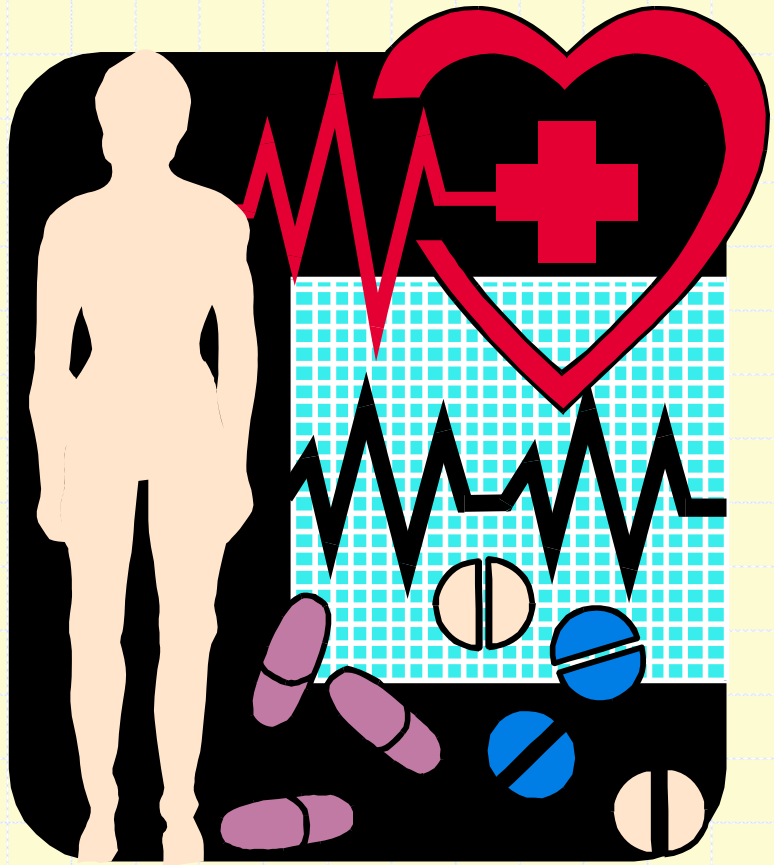


QUANTITATIVE - DISCUSSION

- The program met DCBS and COA standards in all areas investigated except for monthly social worker visits (avg. 1.65) and subsequent reports of abuse/neglect-10%. One report was unsubstantiated while another was on a child in a PCC residential facility.
- Race had no bearing on length of stay or number of placement moves
- POLICY & PRACTICE
- DCBS is employing best practice standards.
- Program follows Family To Family philosophy.
- Program adheres to ASFA standards on length of stay, placement moves, and placement type related to permanency goal. Federal $ tied to these outcomes.

Interview Questions

- What could be done to improve training?
- What isn't working (in the program)?
- What is the most stressful aspect of your role?



Qualitative – Medically Fragile Foster Parent and Social Worker Satisfaction Study.

- **Semi-structured interviews were tape recorded, transcribed,and then coded.**
- **Data documents were coded according to themes.**
- **Themes were placed in three columns and then lines were drawn connecting and collapsing similar themes**
- **These themes were used to code the remaining data documents.**

What could be done to improve training?

- Each agency should have a special CPS training day and say this is what we do and this is what we expect from you.
- I'm a nurse. I get mine out of a book. If I can do my nursing license through a book, take the test, and mail it off, why can't foster parents of respite parents do it?
- When they had the Pilot Project you went through 3 months of total training and then came to the team... not leave for 2 weeks and come back and take care of a case then leave for another 2 weeks.
- ... have some medically fragile social workers there as well to receive some of the same training...
- I think everybody ought to be taught how to talk to doctors.
- ... get specific training from that child's care provider, you know professional people. ... it almost has to be child specific.
- How to get around some of the bureaucracy. How to get from point A to point B.

What isn't working (Foster Parents)?

- We've had 4 or 5 different social workers and I think that's a terrible mistake.
- Every time I go to the hospital they say, "You can't sign because you're not the guardian. Somebody needs to fix it where we can say, "No I'm not the guardian but I can sign for a simple x-ray."
- ...when they release them with 15 different prescriptions and where would I go? Right out here to my 24 hour drug store. We can't fill those. Those are hospital mixes. The hospital won't fill them. If they've got all 15 of them lined up here on the shelf, they put them in the trash. To me that's a sin. So Medicaid has already paid for that once then you've got to come and get it paid for again.
- Respite is rolled in [to the per diem] and they [foster parents] don't like taking it out ... setting it aside.
- We can't make our own appointments at the clinics.

What isn't working (Social Workers)?

- There's too much micromanagement.
- ... we have trouble [with service providers] in as far as they set up so many technical, little hurdles that children and/or families have to meet…
- ... we also get cases back to us where children have either died, so there's no medically fragile [child] there no more, or either the child has improved and is no longer medically fragile ...
- ... one thing I think this program lacks is communication.
- ... we shouldn't get information at the last minute and told to make big changes ...
- ... it frightens me because there is so much cumbersomeness in the system that something is not going to get done and something really bad is going to happen...
- ... a lot of times I don't make referrals ... but I don't have any control over the HELP worker she'll get.

What is the most stressful aspect of your role?

- It's never ending, never ending work.
- the thing that bothers me most is when families really hate me.
- With medically fragile kids, you end up with a lot of appointments. She has infectious disease clinic, she has her pediatrician, dental visits ... I mean you're running constantly...
- All the outside stuff ... it's all the appointments.
- ... just afraid of what might happen to the child...
- The potential for death.
- I find that when it comes time for them to leave that that's the most stressful.
- They [doctors] don't tell us the condition of the baby.
- ... so much paperwork and collateral contacts ...

Qualitative Discussion

- Foster parents were generally more satisfied with the program than workers and made comments such as “I’m proud to be associated with the Cabinet” and “I wished I had done it 10 years ago.”
- Many positive aspects were noted such as smaller caseloads, more individual attention, the team is cohesive & works well together, more timely set up of services, and recent improvements in training.
- Training and coordination could be improved between agencies. More hands-on, child-specific training would be more beneficial. Doctors, nurses, and clinics need to be brought into the loop regarding communication and coordination. A DCBS worker complained that foster parents aren’t given the respect they deserve from doctors.
- Both foster parents and workers would like to be more involved in future changes in policy and procedure.

Final Discussion

- The program is meeting the needs of the medically fragile children and 90% of them are in the least restrictive setting.
- Needed services are acquired more quickly and kids are followed more closely.
- There is a lot of support. Both foster parents and workers support and train one another. A lot of the most useful knowledge is gained through experience.
- Other regions failed COA in this area because they did not have a specific team or worker assigned to cover medically fragile cases. This idea should be duplicated statewide.
- Workers should have some experience and be trained before joining the team.
- ... but then you go see a baby, where all they want to do is breathe ... and they have to have so much just to take one breath and let it out again. It makes your problems seem so miniscule.